22W600 Butterfield Road
Glen Ellyn, IL 60137-6957

Mary M. Furbush, Ed.D.
Executive Director

630-942-5600, Relay Service 711
Fax 630-942-5601

PHYSICIAN'S REFERRAL FOR OCCUPATIONAL THERAPY

NAME: ____ BIRTHDATE: _________________________

PARENT/GUARDIAN/SURROGATE: __________________________ PHONE: _____________________________

HOME ADDRESS: ______________________________________ CITY: _______________________________

SCHOOL: ____ PROGRAM: ____________________________

Therapy programs in education settings may include but are not limited to the areas of developmental motor skills, functional mobility, self-care and sensory/perceptual motor skills. This therapy is provided for exceptional students whose deficits require therapeutic intervention if the students are to benefit from their educational program.

If there are any questions concerning the therapy evaluation or treatment, please contact your assigned therapist.

____

____

_____________________________	_____________	___________________________
(School)	(Phone)	(Therapist's signature)

PHYSICIAN: Please complete the items below and return this form in the enclosed envelope.

Medical diagnosis and/or Description of Concerns: ____

____

Current Medication: ____

Precautions or Contraindications: ____

Assistive Devices: ____

Comments: ____

____

_____________________________	_______________________	__________________
(Physician's Name)	(Address)	(Phone)

I recommend the above named student receive Occupational Therapy.

____		___________________
(Physician's Signature)	NPI (Required)	(Date)

First mailing _______________
Second mailing _______________
Third mailing _______________

The Cooperative Association for Special Education (CASE) is a 21st century organization that collaborates to provide special education services and support for students in our member districts.